IMMEDIATE AND LONG-RANGE PROBLEMS IN THE MUNICIPAL HOSPITALS OF NEW YORK CITY*

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THERE are, in the hospitals of New York City, immediate, short-term pressing needs, and no less important long-term ones. Chronic shortages of personnel such as nurses, social workers, technicians of all categories and of modern laboratory and x-ray equipment and supplies are well known and have been repeatedly documented. Monetary solutions to these problems have, unfortunately, fallen into the too-little–too-late classification. Currently there has been added the monumental problem of house staff shortages. Short-range plans to combat what will otherwise be disaster on July 1, require judicious expenditure of money for the ancillary services, for emergency admitting areas and for the outpatient departments. The more efficient services resulting will mean quicker work-ups and shorter hospital stays.

There can be no issue on the concept of full-time directors of the non-clinical services of Pathology, Radiology and Anesthesiology. The recommendation by Dr. Morris Jacobs and the Board of Hospitals and approval by the Board of Estimate of realistic salaries for Directors of Pathology and Radiology in the three municipal hospitals is applauded. The need in Anesthesiology is, if anything, greater, and more pressing. All municipal hospitals must have the benefit of "full" full-time directors of these three services. The base and middle portions of the pyramid also need strengthening, and technical and clerical staffs throughout must be made adequate.

The hospital emergency service has today replaced the family doctor for a large segment of our citizenry, and is, in most hospitals,

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bursting at the seams. More space, ample on-the-spot x-ray and laboratory facilities are needed as well as additional staff. Separation of the true emergency aspects of this service from those of a convenient after-hours out-patient department must be made. Evening out-patient clinics will provide a partial solution. More selective admissions by better qualified, adequately paid, and carefully supervised admitting physicians, prompt diagnostic work-up and institution of appropriate therapy and early referral of the custodial or chronic patient to suitable facilities, will help resolve the overcrowding of the acute general hospital.

The out-patient department must be engaged more actively in diagnostic work-ups, and the in-patient staff, including directors and senior visiting physicians, should actively concern itself with the quality of care being given in the out-patient department. Extension of realistic per session payments to all physicians in the out-patient department, which accords with present departmental policy, is recommended. These needs have long been known to, and the remedies have been pressed for, by the Department of Hospitals, the Advisory Council and the Co-ordinating Council of the five county Medical Societies. Once these defects are corrected, the greater part of our difficulties will disappear.

On July 1, many of the municipal hospitals will have few or no interns. They can function adequately without them, and without exploiting assistant residents, provided the following steps are taken:

1. Technicians or nurses should be available to draw blood samples for laboratory determinations and to perform intravenous infusions. No legal bar exists to this.
2. The house staff should be relieved of the duty of performing routine ECGs.
3. Secretarial staff and ward clerks should be available in adequate numbers to expedite assembly of reports, to check on prompt performance of diagnostic and therapeutic procedures ordered, to assure prompt arrangements for consultation and to ferret out and retrieve wandering x-ray films.
4. Paid part-time coordinators of house staff education, which we have long recommended, should be provided.
5. The training of the above personnel must begin June 1 in order to effect smooth transition on July 1.

The longer-range program presents more difficulties because much of it is not achievable by purchase. The house staff problem cannot be met by any measure taken locally. It can only be solved by nation-wide action. The twenty new medical schools projected, which have not to my knowledge reached the planning boards, will not fill the gap. Only two measures will help: first, return to the two-year internship, counting the second year as the first year of training for board certification; and secondly, the rationing of the house staff of the prestige institutions. The second proposal is the simplest to implement. Many of these hospitals retain more staff than is needed for service and more than can be properly trained. Approval of a hospital for residency and internship should not be a hunting license; make requirements as rigorous and exacting as possible, but arrange that for every post approved there is a resident available.

It is no news to this gathering that the smaller voluntary hospitals are in greater need of house staff than the have-nots among the municipal hospitals. Twenty-six voluntary acute general hospitals in this City matched six interns of 292 sought. These 26 voluntary acute general hospitals have a bed capacity of 6,812 plus 658 bassinets. I predict that unless the current trend changes, even the largest and most powerful among our famous voluntary hospitals in this City will go the way the lesser voluntaries have gone.

Full-time staffs for Medicine, Surgery, Pediatrics, Obstetrics-Gynecology, with full-time Directors at $25,000 per annum, three Associates at $12,000., and six "bio-chemists" (listed as such for budgetary convenience) have been approved for Harlem and Morrisania Hospitals. This was approved by the Board of Estimate as a "Pilot Project", and pilot projects by definition have a time limit and are then reviewed to judge whether what was sought has been accomplished. We have the Mayor's promise before the full Board of Estimate that nothing will be done without the consent of the Medical Boards of the hospitals concerned. The cost to the City of paying for all professional medical personnel on all services, in all municipal hospitals, is variously estimated at 30 to 50 million dollars annually and the cost to the community in restricting the learning continuum of practicing physicians our city cannot afford.

The full-time system carried to its logical conclusion will lead to what I call the two-doctor system, an elite within the hospitals, and an

inferior order outside. This is the reason I oppose it. Those who think this fanciful are referred to an article with the title "Physicians for Americans" with the subtitle "Two Medical Curricula, A New Proposal". This appears in the March 4, 1961 issue of *The Lancet*. The author is Dr. David Rutstein of Harvard Medical School. He proposes a shortened course for those who will be what he calls "general physicians" and a longer course and more intensive training for the research specialists. The general physician will be trained "in minor surgery, normal obstetrics and out-patient medicine" and be sent into practice "to continue a relationship with the scientist, specialist and hospital". His duties will be "general supervision of health and medical care including preventive medicine, the treatment of minor illnesses, the practice of minor surgery, and perhaps normal obstetrics and screening for early manifestations of . . ." disease. The graduates of the "scientist–specialist" curriculum would be given "appropriate appointments on the specialized services of the teaching hospitals". It is believed by Dr. Rutstein that this will attract more men into medicine, presumably those who cannot make the grade scholastically now. This is problematical. There is danger here, for the doctor of the first instance is the person responsible in the largest measure for the welfare of the patient. Epigastric pain occurring at 2 a.m. may be due to a perforated ulcer, a coronary thrombosis, an incipient acute appendicitis, a renal colic, gall bladder disease, an incarcerated hernia, acute pancreatitis, or a quarrel with one's spouse. Our better brains are needed here. They should not all be siphoned off to the ivory towers.

I should like to quote the following from Volume 15, No. 2, 1960, of the Bulletin of the Hospital Council of Greater New York:

> "Approximately 90 per cent of all services rendered by physicians take place outside the hospital. In the Hospital Council's opinion, it is the obligation of hospitals to reach out to the community and to afford to every physician who practices in the community an opportunity to join a hospital and participate in its work within the limits set by his experience and competence."

Conversely, it is the duty of the doctor engaged in and based for his economic support on the private practice of Medicine to avail himself of this privilege. He must discharge his duties in the care of the indigent sick with diligence and industry. I regret to say that in this respect many

have been remiss, but hope that proper education and leadership will remedy this.

Clinical services in the municipal hospitals must be given direction and must be headed by clinicians, engaged in private practice, who are familiar with the entire spectrum of disease. The doctor in outside practice also must be of the highest calibre since the bulk of medicine's work exists there. Our present system must be preserved and strengthened. Only in this way can first class, not second class, medicine be available both for those in municipal hospitals and for those fortunate enough to be able to pay their own way elsewhere.